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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MATHEW DANIEL FERRON 105 Fantages Way Folsom, CA 95630 Registered Nurse License No. 601776 Respondent.	Case No. 2009-72 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about July 10, 2002, the Board issued Registered Nurse License Number 601776 to Mathew Daniel Ferron ("Respondent") on a probationary basis, as set forth in paragraph 21 below.[1/] Respondent's registered nurse license expired on July 31, 2006.

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1. Respondent completed probation on or about July 10, 2005.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761, subdivision (a), states, in pertinent part, that the Board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
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> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

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7. Code section 4060 states:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.
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> Nothing in this section authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

8. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for himself.

9. Health and Safety Code section 11173, subdivision (a), states, in pertinent part:

> No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . .

Cost Recovery

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

11. "Fentanyl" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(8).

12. "Dilaudid", a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

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13. "Demerol", a brand of meperidine hydrochloride, a derivative of pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17).

14. "Morphine/morphine sulfate" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

MARSHALL HOSPITAL

FIRST CAUSE FOR DISCIPLINE

(Diversion, Possession, and Self-Administration of Controlled Substances)

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that while employed and/or on duty as a registered nurse in the emergency room ("ER") at Marshall Hospital, Placerville, California, Respondent did the following:

Diversion of Controlled Substances:

a. Respondent obtained the controlled substances Fentanyl, Dilaudid, Demerol, and morphine sulfate by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: In or about May 2003, Respondent checked out varying quantities of Fentanyl, Dilaudid, Demerol, and morphine sulfate from the ER narcotics box under the names of several different patients (patients A through E), when, in fact, there were no physician's orders authorizing the medications for the patients (patients A and C), or the quantities of the medications removed were in excess of the doses ordered by the patients' physicians (patients B and D). Further, Respondent failed to chart the administration or wastage of the controlled substances in the medication administration records ("MAR"), or made false statements or grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's records to conceal his diversion of the controlled substances, as set forth in paragraph 17 below. Further, in one instance, Respondent withdrew Fentanyl 100 mcg/2 ml under a patient's name (patient E) when, in fact, the patient was not seen in the emergency room.

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Possession of Controlled Substances:

b. In or about May 2003, Respondent possessed unknown quantities of the controlled substances Fentanyl, Dilaudid, Demerol, and morphine sulfate without valid prescriptions from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation of Code section 4060.

Self-Administration of Controlled Substances:

c. In or about May 2003, Respondent self-administered the controlled substances Fentanyl, Dilaudid, Demerol, and morphine sulfate without lawful authority therefor, as follows: After diverting the controlled substances listed above, Respondent would store them in his bag until his shift was over, then would take them home for his personal use. Once he arrived home, Respondent would inject the narcotics both intravenously and intramuscularly in his arm and legs so that he could get the immediate and delayed effects of the narcotics.

SECOND CAUSE FOR DISCIPLINE

(Use of Controlled Substances to an Extent or in a Manner Dangerous or Injurious to Oneself or Others)

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (b), in that in or about May 2003, while employed as a registered nurse in the ER at Marshall Hospital, Placerville, California, Respondent used the controlled substances Fentanyl, Dilaudid, Demerol, and morphine sulfate to an extent or in a manner dangerous or injurious to himself and/or others, as set forth in subparagraph 15 (c) above.

THIRD CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in or about May 2003, while employed and on duty as a registered nurse in the ER at Marshall Hospital, Placerville, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other

records pertaining to the controlled substances Fentanyl, Dilaudid, Demerol, and morphine sulfate, as follows:

Patient A:

a. On May 19, 2003, at 1905 hours, Respondent signed out on the Controlled Substance Record Fentanyl 100 mcg under Patient A's name when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Fentanyl 100 mcg on the patient's MAR and otherwise account for the disposition of the Fentanyl 100 mcg.

Patient B:

b. On May 19, 2003, at 1920 hours, Respondent signed out on the Controlled Substance Record Dilaudid 2 mg under Patient B's name when, in fact, the physician's order called for the administration of Dilaudid 1 mg for the patient. Further, Respondent charted on the patient's MAR that he administered Dilaudid 1 mg to the patient at 1924 hours, but failed to chart the wastage or otherwise account for the disposition of the remaining 1 mg of Dilaudid.

Patient C:

c. On May 20, 2003, at 0220 hours, Respondent signed out on the Controlled Substance Record Demerol 75 mg under Patient C's name when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Demerol 75 mg on the patient's MAR and otherwise account for the disposition of the Demerol 75 mg.

d. On May 20, 2003, at 0224 hours, Respondent signed out on the Controlled Substance Record Fentanyl 100 mcg under Patient C's name when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Fentanyl 100 mcg on the patient's MAR and otherwise account for the disposition of the Fentanyl 100 mcg.

Patient D:

e. On May 19, 2003, at 2047 hours, Respondent signed out on the Controlled Substance Record morphine sulfate 10 mg under Patient D's name when, in fact, the physician's

order called for the administration of morphine sulfate 5 mg for the patient. Further, Respondent charted on the patient's MAR that he administered morphine sulfate 5 mg to the patient at 2055 hours, but failed to chart the wastage or otherwise account for the disposition of the remaining 5 mg of morphine sulfate.

Patient E:

f. On May 19, 2003, at 2214 hours, Respondent signed out on the Controlled Substance Record Fentanyl 100 mcg under Patient E's name when, in fact, the patient was not seen in the ER on that date.

SUTTER GENERAL HOSPITAL

FOURTH CAUSE FOR DISCIPLINE

(Diversion, Possession, and Self-Administration of Controlled Substances)

18. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that while employed and/or on duty as a registered nurse in the ER at Sutter General Hospital, Sacramento, California, Respondent did the following:

Diversion of Controlled Substances:

a. Respondent obtained the controlled substances Dilaudid and Demerol by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: In and between March and April 2006, Respondent withdrew extra dosages of Dilaudid and/or Demerol from the hospital's Pyxis system[2] for patients who had legitimate orders for the medication, administered the narcotics to the patients as ordered, then kept the additional doses for himself. Further, Respondent withdrew Dilaudid from the Pyxis under the names of several different patients when, in fact, there were no physician's orders authorizing the medication for the patients, failed to chart the administration or wastage of the

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2. The Pyxis is a computerized medication administration system manufactured by Cardinal Health. Individual licensed personnel are assigned a password to access the Pyxis by the hospital or health care agency Pharmacy Department. The system can thus identify users, the time they log in and out of the system, and their activities while logged in the system, enabling the hospital or other health care agency to identify medication discrepancies.

Dilaudid on the patients' MAR's, or made false statements or grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's records to conceal his diversion of Dilaudid, as set forth in paragraph 20 below.

Possession of Controlled Substances:

b. In and between March and April 2006, Respondent possessed unknown quantities of the controlled substances Dilaudid and/or Demerol without valid prescriptions from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation of Code section 4060.

Self-Administration of Controlled Substances:

c. In and between March and April 2006, Respondent self-administered the controlled substances Diluadid and/or Demerol without lawful authority therefor, as follows: After diverting the controlled substances listed above, Respondent would store them in his bag until his shift was over, then would take them home for his personal use. Once he arrived home, Respondent would inject the narcotics both intravenously and intramuscularly in his arm and legs so that he could get the immediate and delayed effects of the narcotics.

FIFTH CAUSE FOR DISCIPLINE

(Use of Controlled Substances to an Extent or in a Manner Dangerous or Injurious to Oneself or Others)

19. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (b), in that in and between March and April 2006, while employed as a registered nurse in the ER at Sutter General Hospital, Sacramento, California, Respondent used the controlled substances Dilaudid and/or Demerol to an extent or in a manner dangerous or injurious to himself and/or others, as set forth in subparagraph 18 (c) above.

SIXTH CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

20. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section

2762, subdivision (e), in that in and between March and April 2006, while employed and on duty as a registered nurse in the ER at Sutter General Hospital, Sacramento, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substance Dilaudid as follows:

Patient A:

a. On March 25, 2006, at 1233 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient A's name and charted on the patient's MAR that he administered the Dilaudid to the patient at 1425 hours. In fact, there was no physician's order authorizing the medication for the patient.

b. On March 25, 2006, at 1426 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient A's name, when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Dilaudid on the patient's MAR and otherwise account for the disposition of the Dilauid 2 mg.

Patient B:

c. On March 25, 2006, at 1755 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient B's name and charted on the patient's MAR that he administered the Dilaudid to the patient at 1753 hours. In fact, there was no physician's order authorizing the medication for the patient.

d. On March 25, 2006, at 1830 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient B's name and charted on the patient's MAR that he administered the Dilaudid to the patient at 1935 hours. In fact, there was no physician's order authorizing the medication for the patient.

Patient C:

e. On April 25, 2006, at 1125 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient C's name, when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration

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or wastage of the Dilaudid on the patient's MAR and otherwise account for the disposition of the Dilauid 2 mg.

Patient D:

f. On April 13, 2006, at 1243 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient D's name, when, in fact, the physician's order called for the administration of Dilaudid 1 mg for the patient. Further, Respondent charted on the patient's MAR that he administered Dilaudid 1 mg to the patient at 1241 hours, but failed to chart the wastage or otherwise account for the disposition of the remaining 1 mg of Dilaudid.

g. On April 13, 2006, at 1649 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient D's name, when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Dilaudid on the patient's MAR and otherwise account for the disposition of the Dilauid 2 mg.

Patient E:

h. On April 20, 2006, at 2121 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient E's name, when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Dilaudid on the patient's MAR and otherwise account for the disposition of the Dilauid 2 mg.

Patient F:

i. On April 20, 2006, at 1405 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient F's name, when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Dilaudid on the patient's MAR and otherwise account for the disposition of the Dilauid 2 mg.

Patient G:

j. On April 20, 2006, at 1148 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient G's name, when, in fact, there was no physician's order

authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Dilaudid on the patient's MAR and otherwise account for the disposition of the Dilauid 2 mg.

Patient H:

k. On April 18, 2006, at 2201 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient H's name, when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Dilaudid on the patient's MAR and otherwise account for the disposition of the Dilauid 2 mg.

Patient J:

l. On April 18, 2006, at 1659 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis system under Patient J's name, when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration or wastage of the Dilaudid on the patient's MAR and otherwise account for the disposition of the Dilauid 2 mg.

DISCIPLINE CONSIDERATIONS

21. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges as follows: On May 16, 2002, pursuant to the Stipulated Settlement and Disciplinary Order adopted by the Board as its Decision in the matter titled *In the Matter of the Statement of Issues Against Mathew Daniel Ferron,* Case No. 2002-122, the Board granted Respondent's application for registered nurse license by endorsement effective June 15, 2002. The Board further ordered that upon issuance of Respondent's registered nurse license, the license shall immediately be revoked, the order of revocation stayed, and Respondent placed on probation for a period of three (3) years on terms and conditions. Pursuant to the Stipulation, Respondent admitted that he unlawfully diverted, possessed, and self-administered the controlled substances morphine, Dilaudid, Demerol, and Vicodin while working as a registered nurse with a temporary license at Mercy Hospital of Folsom, California, and that he unlawfully possessed and self-administered the controlled substance hydrocodone on March 20, 2001 (on March 20, 2001,

Respondent, after being interviewed by the Division of Investigation, Department of Consumer Affairs, submitted a urine specimen for a drug test and tested positive for hydrocodone).

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 601776, issued to Mathew Daniel Ferron;

2. Ordering Mathew Daniel Ferron to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/23/08.

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

03579-110-SA2008301688
phd: 09/04/2008